OAH 3-0900-22382-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE COMMISSIONER OF HEALTH

In the Matter of St. Therese Home
Survey Exit Date: August 26, 2011

RECOMMENDED DECISION

The above matter was the subject of an independent informal dispute resolution (IIDR) conducted by Administrative Law Judge Kathleen D. Sheehy on January 12, 2012. The record of the Office of Administrative Hearings (OAH) closed at the conclusion of the IIDR conference that day.

Christine Campbell, IIDR Coordinator, Division of Compliance Monitoring (Division), 320 W. Second Street, Room 703, Duluth, MN 55802-1402, appeared for the Division. Mary Cahill, Department of Health, also participated in the conference.

Susan M. Voigt and Joel D. Sedgeman, Voigt, Rodè & Boxeth, LLC, 2550 University Avenue West, Suite 190 South, St. Paul, MN 55114, appeared for St. Therese Home (Facility). Denise Barnett, Administrator; Stacy Lind, Director of Nursing; Sandra Delgehausen, Assistant Director of Nursing; Marcy Vogt, Quality Improvement and Quality Assurance Therapy Manager; Kim Mills, LPN; and Dr. Nick Schneeman and Larry Reger participated in the conference on behalf of the Facility.

FINDINGS OF FACT

1. On August 26, 2011, the Division issued a Statement of Deficiencies to the facility, citing violations of Tag F 356 (staff posting) and F 373 (use of paid feeding assistants). The Division found deficient the Facility's use of paid feeding assistants for Residents # 104, 261, 363, 215, 334, 21, and 315.[1]

2. On August 23, 2011, at 4:15 p.m., the Division had determined that there was an immediate and serious threat to the health and safety of Residents # 104, 261, 363, 215, 334, and 21 based on the use of paid feeding assistants. The Facility submitted a corrective action plan that included, among other things, discontinuation of the use of paid feeding assistants. On August 26, 2011, the Division removed the immediate jeopardy determination.

Tag F 356 (Staff Posting)

3. Federal regulations require that the facility post, on a daily basis, *the total number and the actual hours worked by the following categories* of licensed and unlicensed nursing staff directly responsible for resident care per shift: *registered nurses, licensed*

[1] Form 2567, Ex. G. The Facility initially disputed Tags F 276 (quarterly assessment) and F 323 (accidents), but it withdrew those disputes before the IIDR conference. *See* email to ALJ dated Jan. 9, 2012.

practical nurses, and certified nurse aides. The facility must post the nurse staffing data on a daily basis at the beginning of each shift, in a clear and readable format, and in a prominent place readily accessible to residents and visitors.[2]

4. The facility's practice at the time of the survey was to post information describing the number of full-time equivalent licensed and unlicensed staff scheduled to work for all three shifts. The posting was done once per day at the beginning of the day. For example, the posting for August 17, 2011, provided that there were 17 full-time equivalent (FTE) licensed nursing staff on the day shift, 15 on the evening shift, and 8 on the night shift. For the same date, there were 37 FTE unlicensed nursing staff on the day shift, 34 on the evening shift, and 12 on the night shift.[3]

5. The Facility generally schedules licensed staff members for eight-hour shifts, but unlicensed staff may work shorter shifts in the evenings.

6. Surveyors cited the Facility for failing to include actual hours worked in the posted data.[4]

Tag F373

7. Federal regulations permit the use of a paid feeding assistant (in lieu of a licensed staff member or a nursing assistant) to feed residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.[5]

8. None of the residents at issue here had active diagnoses of dysphagia (difficulty swallowing) or active difficulty with swallowing at the time of the survey, although they may have had swallowing issues evaluated in the past. All of the residents at issue here had notations in their care plans that safe swallowing strategies were to be followed. The Facility maintains that these strategies are the standard of practice for all residents and did not need to be included in the care plan of any of them. After the survey, these references were removed from the care plans.[6]

9. The Facility did not document in the care plan of any resident that the resident was eligible for assistance by a paid feeding assistant (PFA). The Facility's practice was to document by exception; in other words, the Facility would document in a care plan if a resident was not eligible for assistance by a PFA.[7] The Facility did maintain a list of persons who were eligible to be fed by a PFA; however, the list was prepared for the purpose of demonstrating to surveyors that the Facility was in compliance with the regulation, and it was not a part of the residents' clinical record.[8] Before each meal, the charge nurse would assess the current

[2] 42 C.F.R. § 483.30(e) (emphasis added).
[3] Ex. DD-1; Ex. G-24 (Form 2567).
[4] Ex. G-24.
[5] 42 C.F.R. § 483.35(h).
[6] Comment of Sandra Delgehausen.
[7] *Id.*; see also Ex. 10 (policy document providing that case manager will document on a resident's care plan if the resident cannot be fed by a meal companion and make a notation in the NAR care guide).
[8] Ex. 16.

condition of eligible residents and decide whether the resident could be fed by a personal feeding assistant.[9]

10. The Facility's written policy for the PFA program provides that meal companions may assist residents who have cognitive impairments or dementia, visual or hearing impairments, poor control of arms or hands, decreased strength or endurance, or contractures in hands. The policy document further provides that meal companions may not assist residents who have complicated feeding problems or clinical conditions such as recurrent aspirations, difficulty swallowing, tendency to choke, or a feeding tube.[10]

11. The Facility had a specific written policy that a PFA may feed a resident who has safe swallowing strategies in place, if it is determined to be safe based on the judgment of a licensed nurse. Education of the PFA was to be completed verbally.[11]

12. The Facility's PFA program has been in place since 2004. In the numerous surveys that have taken place since that time, no surveyor has ever suggested that there was a problem with the way the Facility was implementing the program.[12]

Resident # 104

13. This resident was a 99-year-old woman was admitted originally in November 2008. At that time she had numerous diagnoses including dementia, and she had a history of aspiration pneumonia. The resident refused to have the texture of her food modified, and she refused a speech and language evaluation.[13]

14. On or about June 18, 2009, the resident sustained a hip fracture and was hospitalized. During the hospitalization, the resident had difficulty swallowing and was placed on a dysphagia diet.[14]

15. Upon readmission to the facility she was seen by a speech and language pathologist on June 23, 2009, for evaluation of chewing and swallowing function and was given a treatment diagnosis of dysphagia (difficulty swallowing).[15] While receiving these services, the resident was returned to the hospital on June 30, 2009, and diagnosed with pneumonia.[16] There is nothing in the IIDR record to indicate that this was aspiration pneumonia contracted at the Facility, and the Department has not asserted that it was.[17]

16. On July 9, 2009, the resident was discharged from speech and language pathology services. The discharge summary provides that the resident was evaluated and treated to determine the best diet, and her caregivers were trained in safe swallowing recommendations. She was on a mechanical soft diet (food that is ground or finely chopped) with thin liquids permitted through a waiver signed by her son.[18]

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[9] Comment of Sandra Delgehausen.
[10] Ex. 11.
[11] Ex. 13.
[12] Comment of Sandra Delgehausen.
[13] Ex. 3 at 35.
[14] Ex. G-27.
[15] Ex. 3 at 36.
[16] Ex. G-28.
[17] *Id.*
[18] Ex. 3 at 36-37.

17. The safe swallowing recommendations were: oral cares following all meals, no straws, small bites (1/4 teaspoonful of food per bite), alternate bites of food with liquid to clear oral residue, sit upright 90 degrees for meals, feed only when alert, encourage to eat slowly, keep head down when swallowing drinks.[19]

18. In June 2010, the resident's physician ordered a mechanical soft diet high in protein with thin fluids.[20]

19. The Facility monitored the resident's nutritional status carefully to prevent weight loss and ensure adequate fluid intake. All nutritional charting reflects that the resident was tolerating the mechanical soft diet well. She also received nutritional supplements.[21]

20. As of August 2, 2011, the resident had no medical diagnosis of any swallowing disorder.[22] Her Minimum Data Set (MDS) assessment on July 11, 2011, reflected that she was eating with extensive assistance but had no signs or symptoms of a swallowing disorder, was on a mechanically altered diet, and was receiving no speech or language pathology services.[23] A quarterly nutritional assessment conducted in July 2011 concluded that she had no swallowing disorder and was tolerating her diet.[24]

21. The resident's care plan described the waiver signed by the resident's son to allow the resident to accept food and fluids of choice for her own comfort. The interventions included extensive assistance with feeding; monitor for chewing/swallowing problems, report to nurse; safe swallowing strategies in place; and diet per physician orders.[25]

22. In August 2011, at the time of the survey, the resident was being fed by a PFA. The Facility's most recent assessment and the resident's clinical record reflected that the resident had no current difficulties swallowing her food and that she was tolerating her diet well.

23. During the survey, the PFA who was feeding the resident stated to a surveyor that this resident had no special feeding strategies. This statement is consistent with the Facility's position that the use of safe swallowing strategies was the standard of care for all residents.

24. In order to lift the immediate jeopardy, the Division required the Facility to amend this resident's care plan to provide she was not eligible for use of a PFA.[26] The resident's family believes this decision adversely affected the resident's quality of life.[27]

Resident #261

25. This resident was a 94-year-old woman originally admitted to the Facility in August 2009. Her diagnoses included dementia and chronic obstructive pulmonary disease

[19] Ex. 3 at 38.
[20] Ex. 3 at 1.
[21] Ex. 3 at 41-44.
[22] Ex. 3 at 1.
[23] Ex. 3 at 3, 8, 12, and 15.
[24] Ex. 3 at 20.
[25] Ex. 3 at 28.
[26] Ex. 3 at 26.
[27] Comment of Larry Reger.

(COPD) but no swallowing disorders. She had no history of aspiration pneumonia. She was on a regular diet, half portions.[28]

26. On September 4, 2009, the resident was referred for a dysphagia evaluation due to episodes of coughing. She was eating a regular diet with no reported difficulties swallowing. The speech and language pathologist recommended no change to her diet, and the resident was discharged from therapy at the end of the month.[29] Safe swallowing recommendations for this resident included: double swallow (two times for each bite or drink), clear throat periodically, remain upright 30 minutes after meals, and take small bites of ¼ teaspoon.[30]

27. In November 2010, the resident was screened by speech therapy again and observed to cough with intake of food. No recommendations for change were made as a result of this screen.[31]

28. On January 14, 2011, the resident was diagnosed with bilateral pneumonia, likely from aspiration.[32] No change in her diet was ordered.[33]

29. On March 16, 2011, her physician noted that she needed more help with eating because she did not stay on task at mealtime and was no longer able to feed herself.[34] In April 2011, her physician noted that she had an intermittent cough and that her voice was hoarse. The resident's family believed the cough was from post-nasal drip, and she was taking Claritin for it.[35]

30. As of August 2, 2011, the resident had no medical diagnosis of any swallowing disorder.[36] Her Minimum Data Set (MDS) assessment on July 25, 2011, reflected that she was eating with extensive assistance but had no swallowing disorder and was receiving no speech or language pathology services.[37] A quarterly nutritional assessment conducted on July 28, 2011, reflects the resident had no swallowing disorder, good intake of food and fluids and no nutritional concerns. She was still eating a regular diet, half portions.[38]

31. The resident's care plan identified swallowing issues as a problem, with the resident eating a regular diet, half portions, and receiving extensive assistance for meals. It notes that she was fed at least 75% of each meal and that she should be monitored for chewing/swallowing problems. Safe swallowing strategies were in place, and she was to remain upright for 30 minutes after meals.[39]

32. In August 2011, at the time of the survey, a nursing assistant advised the surveyors that this resident was being fed by a PFA and that the resident coughed when being fed. The Facility's most recent assessment and the resident's clinical record reflected that the

[28] Ex. 4 at 29.
[29] Ex. 4 at 30.
[30] Ex. 4 at 32.
[31] Ex. 4 at 33.
[32] Ex. 4 at 35.
[33] Ex. 4 at 1.
[34] Ex. 4 at 42, 46.
[35] EX. 4 at 43.
[36] Ex. 4 at 1.
[37] Ex. 4 at 7, 11, and 14.
[38] Ex. 4 at 20; Ex. W-11.
[39] Ex. 4 at 26.

resident had no current difficulty swallowing her food; that she needed help with eating because of her dementia, not because of her cough; and that she had a history of a single (not recurrent) episode of lung aspiration.

33. In order to lift the immediate jeopardy, the Division required the Facility to amend this resident's care plan to provide that she was not eligible for use of a PFA.[40]

Resident 363

34. This resident was an 89-year-old woman who was admitted to the Facility in January 2010. She had numerous diagnoses, including dementia. She had a history of dysphagia, unspecified.[41] Upon admission she was eating a regular diet.

35. The resident was referred for a dysphagia evaluation in July 2010 for "pocketing" of food in her mouth. The speech language pathologist recommended the use of a mechanical soft diet with thin liquids, and the resident was referred to a fitness program.[42] Safe swallowing recommendations included remaining upright for 30 minutes after meals, running tongue on teeth to clear residue, small bites (1/4 teaspoonful of food per bite), sitting upright at 90 degrees for meals, and reduce distractions.[43] The resident was discharged from speech and language pathology services on August 31, 2010, having met her therapy goal of safely consuming increasingly textured meat items.[44]

36. On August 31, 2010, the resident's physician ordered a mechanical soft diet with thin fluids, small servings.[45]

37. As of August 8, 2011, the resident had no current dysphagia diagnosis.[46] The MDS assessment on May 31, 2011, provided that she ate a mechanically altered diet with limited assistance, she had no signs or symptoms of a swallowing disorder, and she was not receiving any speech or language pathology services.[47] The quarterly nutritional assessment on June 1, 2011, reflected that she was eating with limited assistance.[48]

38. The resident's care plan identified "swallowing issues" as a problem based on her history of dysphagia. The interventions included mechanical soft diet with thin liquids, small servings; provide supervision assistance with eating/meal set up, accompany to table to eat, set up meal, cue and encourage; and safe swallowing strategies in place.[49]

39. In August 2011, at the time of the survey, a surveyor observed the resident being assisted by a PFA. Two PFAs advised the surveyor that they could feed residents on that floor

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[40] Ex. 4 at 26.
[41] Ex. 5 at 1-2.
[42] Ex. 5 at 32.
[43] Ex. 5 at 31.
[44] Ex. 5 at 32; Ex. X-12. The 2567 contains a typographical error; it refers to the speech therapy discharge date as "8/31/11" instead of 8/31/10. *See* Ex. G-34. In addition, the 2567 erroneously refers to a "restorative fitness program" the resident was participating in as a program recommended by the speech therapist; this was in fact a nursing program aimed at providing the resident with companionship, not a speech therapy program. *See* Comment of Sandra Delgehausen.
[45] Ex. 5 at 1-2.
[46] Ex. 5 at 1.
[47] Ex. 5 at 8, 12, & 15.
[48] Ex. 5 at 22.
[49] Ex. 5 at 27.

unless the residents were restricted to thickened liquids.[50] A surveyor observed a PFA providing a single green bean to the resident that was larger than ¼ teaspoon. The surveyor requested that the assistant director of nursing stop the feeding of the resident, and the assistant director of nursing completed the meal with the resident.[51]

40. The Facility's most recent assessment and the resident's clinical record reflected that the resident had no current diagnosis of dysphagia and had no difficulty swallowing her food after her discharge from speech and language pathology services. She often fed herself entirely on her own. The surveyor indicated to the Facility that if the resident was on a mechanical soft diet, that fact alone meant the resident had swallowing problems and should not be fed by a PFA.

41. In order to lift the immediate jeopardy, the Division required the Facility to amend the resident's care plan to provide that she would not be fed by a PFA.[52]

Resident # 215

42. This resident was a 77-year-old man who was admitted to the Facility in March 2007. His many diagnoses included dementia and diabetes. His physician ordered a diet with No Concentrated Sweets (NCS), regular texture, thin fluids.[53]

43. On May 27, 2010, the resident was referred for a dysphagia evaluation because she had been coughing with liquids. When she was discharged from speech therapy on June 17, 2010, the therapist recommended continuing with the same diet.[54] Safe swallowing strategies included: taking small bites (1/4 teaspoonful of food per bite), alternating food with liquids, feed only when alert, and make sure mouth is clear before next bite or drink is offered.[55]

44. On May 5, 2011, the NCS diet was discontinued and a regular diet was put in place.[56]

45. As of May 2, 2011, the resident had no medical diagnosis of any swallowing disorder. The MDS assessment performed on June 28, 2011, provided that he was totally dependent on others for eating, that he had no signs or symptoms of a possible swallowing disorder, and that he was receiving no speech therapy services.[57] The quarterly nutritional assessment conducted on June 30, 2011, provided that he had no swallowing disorder and no nutritional concerns.[58]

46. The resident's care plan provided that he was using safe swallowing strategies per speech therapy. His care plan, unlike the others, explicitly provided that he could be fed by a meal companion; however, this resident was never fed by a PFA, and he was not being fed by a PFA at the time of the survey.[59] The resident's wife was very involved in his care, and he

[50] Ex. G-31.
[51] Ex. G-32.
[52] Ex. 5 at 26.
[53] Ex. 6 at 1.
[54] Ex. 6 at 37.
[55] Ex. 6 at 36.
[56] Ex. 6 at 21.
[57] Ex. 6 at 8, 12, 15.
[58] Ex. 6 at 20; Ex. V-15.
[59] Ex. 6 at 26.

was fed only by his wife or by a nursing assistant.[60] The surveyors did not observe a PFA feeding this resident, but because two PFAs indicated they could feed any resident not restricted to thickened liquids, and because this resident was on the Facility's list of residents eligible for a PFA, they concluded that PFAs had fed this resident.[61]

47. In order to lift the Immediate Jeopardy, the Division required the Facility to amend the resident's care plan to provide that he would not be fed by a meal companion.[62]

Resident # 334

48. This resident was an 84-year-old woman originally admitted to the facility in December 2008. Her diagnoses included dementia with behavioral issues and malnutrition. She had no history of swallowing disorders.[63]

49. In March 2010, the resident was referred for a dysphagia evaluation because she had been spitting out her food. At the time, the resident was a mechanical soft diet with thin liquids. When the resident was discharged from speech therapy on April 5, 2010, the speech therapist concluded that the resident would be able to continue this diet and that the spitting was a behavior due to her dementia, not a swallowing problem.[64] The recommended safe swallowing strategies were: remain upright for 30 minutes after a meal, take small bites (1/2 teaspoonful per bite), alternate food and liquids, sit upright at 90 degrees for meals, and tell the resident to "swallow food."[65]

50. As of July 7, 2011, the resident had no diagnosis of a swallowing disorder.[66] The MDS assessment conducted on July 6, 2011, provided that the resident required extensive assistance with meals, had no signs of symptoms of a possible swallowing disorder, was on a mechanically altered diet, and was receiving no speech therapy services.[67] The quarterly nutritional assessment performed on July 11, 2011, provided that the resident required limited assistance at meals.[68] A nutrition chart note on the same date indicated that the resident was tolerating textures and had improved oral intake.[69]

51. The resident's care plan provided that the resident had "swallowing issues." The interventions included extensive assistance with eating, encourage self-feeding; needs encouragement throughout meal to eat; diet as ordered by physician; monitor for chewing/swallowing problems, report to nurse; safe swallow strategies in place.[70]

52. At the time of the survey, a PFA was helping the resident eat breakfast.

53. In order to lift the Immediate Jeopardy, the Division required the Facility to amend this resident's care plan to provide that she could not be fed by a meal companion.[71]

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[60] Ex. 6 at 31-35; comment of Sandra Delgehausen.
[61] Ex. G-36, G-37.
[62] Ex. 6 at 26.
[63] Ex. 7 at 1.
[64] Ex. 7 at 32-34.
[65] Ex. 7 at 35.
[66] Ex. 7 at 1.
[67] Ex. 7 at 8, 12, 15.
[68] Ex. 7 at 20
[69] Ex. 7 at 21.
[70] Ex. 7 at 26.
[71] Ex. 7 at 26.

Resident # 21

54. Resident # 21 was a 99-year-old woman who was originally admitted to the Facility in March 2006. She had diagnoses including dementia, asthma and other respiratory diseases, and adult failure to thrive. Her physician ordered a regular diet with thin fluids. She had no history of swallowing disorders.[72]

55. The nutrition chart reflects that this resident had chewing issues due to poorly fitting dentures and needed to have her meat cut. The note further reflects that the resident tolerated this well and there were no swallowing concerns.[73]

56. In March 2011, the resident developed pneumonia. She started antibiotic treatment on March 18, 2011. There is nothing in the IIDR record to suggest that the pneumonia was caused by aspiration rather than the resident's chronic respiratory problems; her physician ordered no change to the resident's diet at this time.[74]

57. This resident was never referred for a dysphagia evaluation.

58. On June 17, 2011, a nutrition note reflects that the resident had decreased appetite since recovering from pneumonia and had lost approximately ten pounds in six months. On August 3, 2011, her physician ordered a change to a mechanical soft diet to see whether the resident would eat more in order to improve or stabilize her weight.[75]

59. As of August 4, 2011, the resident had no current or past diagnosis of any swallowing disorder.[76] The MDS assessment conducted on June 16, 2011, provided that the resident required extensive assistance with eating, had no signs or symptoms of a swallowing disorder, and was receiving no speech therapy services.[77] A quarterly nutritional assessment on June 17, 2011, provided that the resident had no swallowing disorder and required limited assistance with meals.[78]

60. The resident's care plan provided that she had broken teeth and her dentures would not be replaced (based on the family's decision). There is no reference to any chewing or swallowing problem. Interventions included diet as ordered by the physician with extensive assistance; feed as needed; monitor the need to change texture; will often refuse staff help; encourage; needs assistance for location of food items, rotating bowls/cups during meal.[79]

61. During the survey, a PFA identified the resident as someone she feeds on a regular basis.[80]

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[72] Ex. 8 at 1.
[73] Ex. 8 at 4.
[74] Ex. 8 at 1.
[75] Ex. 8 at 3, 4. The 2567 erroneously provides that the resident's diet was changed "because of her problems with her missing teeth/dentures that family will not be replacing." *See* Ex. G-38. The chart note in question does not say this (*see* Ex. 8 at 4), and the record is clear that the physician changed the resident's diet to try to improve her appetite and stabilize her weight. *See* Ex. 8 at 3 (physician note, "mech soft diet – to see if intake/wt stabilizes/improves"). The 2567 also states erroneously that the resident "was recently changed to a mechanical soft diet due to chewing problems because of dentures." *See* Ex. G-39.
[76] Ex. 8 at 1.
[77] Ex. 8 at 10, 14, 17.
[78] Ex. AA-2, 3.
[79] Ex. 8 at 26.
[80] Ex. G-39.

62. In order to lift the Immediate Jeopardy, the Division required the Facility to amend the resident's care plan to provide that she would not be fed by a meal companion.[81]

Resident # 135

63. This resident was a 92-year-old woman who was admitted to the Facility from the hospital in October 2010 with diagnoses including dementia and dysphagia.[82] She was referred for a dysphagia evaluation upon admission because of her decreased swallowing ability while hospitalized. Before her hospitalization, the resident had been eating a regular diet.[83] When the resident was discharged from speech therapy on November 17, 2010, the therapist recommended that she return to a regular diet with thin liquids.[84] The following safe swallowing strategies were recommended: double swallow, remain upright for 30 minutes after meals, small bites (1/4 teaspoonful of food per bite), alternate bites of food with liquids, sit upright 90 degrees for meals.[85]

64. The therapist noted that the resident tolerated the diet well and was independently able to implement these strategies.[86]

65. The resident's MDS assessment dated June 13, 2011, reflects that the resident was able to eat with supervision; she had a diagnosis of dysphagia, unspecified; she had no signs or symptoms of a possible swallowing disorder; and she was receiving no speech therapy services.[87] A quarterly nutritional assessment dated June 13, 2011, provided that the resident had no swallowing disorders and was able to eat with limited assistance.[88]

66. The resident's care plan provided that she had a history of chewing/swallowing concerns. Interventions were described as regular diet with thin liquids, per physician order; encourage fluid intake; monitor for changes in chewing/swallowing ability; provide assistance with meal set up and supervision; and safe swallowing strategies per speech therapy.[89]

67. This resident's name was on the list of residents eligible to be fed by a PFA, but she continued to eat independently and was never fed by a PFA. She sat with other residents who were fed by a PFA.[90]

68. The Division did not include this resident in the determination of immediate jeopardy, and it required no change to her care plan.

Immediate Jeopardy

69. Division cited Facility for failing to ensure that residents with complicated feeding problems received safe and appropriate assistance with eating. It further determined that Residents # 104, 261, 363, 215, 334, and 21 were in immediate jeopardy but that Resident #

[81] Ex. 8 at 26.
[82] Ex. 9 at 45.
[83] Ex. 9 at 46.
[84] Ex. 9 at 46; Ex. BB-23.
[85] Ex. 9 at 48.
[86] *Id.*
[87] Ex. 9 at 14, 18, 22, 28.
[88] Ex. 9 at 2-3.
[89] Ex. 9 at 42.
[90] Comment of Sandra Delgehausen.

135 was not.[91] When the immediate jeopardy was lifted, the noncompliance remained at a reduced scope and severity of no actual harm with the potential for more than minimal harm, with a pattern.[92]

Conclusion

70. These residents did not have complicated feeding problems at the time of the survey, and the Facility did not fail to ensure that they were fed safely; however, the Facility failed to adequately document eligibility for use of a PFA in the care plans of these residents, and it also failed to revise the care plans as necessary to reflect current problems, or lack thereof. Tag F 373 should be rescinded and replaced with Tag 280 (failure to review and revise the care plan)**.**

Based upon the exhibits submitted and the arguments made and for the reasons set out in the Memorandum that follows, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

The citation with regard to Tag F356 is supported by the facts and should be AFFIRMED as to scope and severity; the citation with regard to Tag F 373 is not supported by the facts; it should be RESCINDED and replaced with Tag F 280, issued at severity level 2, no actual harm but with the potential for more than minimal harm that is not immediate jeopardy; and with a scope of 3 (a systemic failure). The findings in the 2567 should be revised accordingly.

Dated: January 26, 2012. s/Kathleen D. Sheehy

KATHLEEN D. SHEEHY
Administrative Law Judge

Reported: Digital recording (no transcript)

NOTICE

Under Minn. Stat. § 144A.10, subd.16 (d)(6), this recommended decision is not binding on the Commissioner of Health. Under Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this recommended decision.

[91] Ex. G-26.
[92] Ex. G-27.

MEMORANDUM

Tag F356

The posting of nurse staffing information is required by 42 C.F.R. § 483.30(e), which provides, in relevant part:

> Nurse staffing information—(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides.[93]

The purpose of the regulation is to ensure that the required data is available to the public on a daily basis. The Facility argues that the regulation is unclear and that it is impossible to post actual hours worked for each shift at the beginning of the shift, unless the intent is to post hours worked the day before.

When the rule was adopted, the Centers for Medicare & Medicaid Services (CMS) discussed both its initial proposal and the reasons for making changes in the initially proposed rule. CMS originally proposed that facilities post a specific CMS-approved form each day to indicate the number of FTEs of registered nurses, licensed practical nurses, and certified nurse aides directly responsible for patient care. Commenters pointed out that the use of FTEs may make it difficult for the public to understand the substance of the information, and that many facilities have non-standard or overlapping shifts that do not fit the traditional notions of day, evening, and night shifts.

In response to these comments, CMS revised the rule to allow facilities to use their own forms and eliminated the FTE calculation; instead, it required facilities to post the number of nursing staff aggregated by category (RN, LPN, and CNA). In addition, it incorporated the reference to "actual hours worked" to allow facilities to identify shift breakdowns so that 24-hour staffing coverage can be determined in an accurate manner. For example, a facility may have four licensed RNs scheduled to work during different portions of the day shift; the inclusion of "actual hours worked" was intended to address the shift breakdowns on that particular shift. If one RN worked from 7 a.m. to 3 p.m., two RNs worked 7 a.m. to 11 a.m., and one RN worked 11:00 a.m. to 3:00 p.m., those actual hours would be reported on the form, along with the staffing total, which amounts to 2.5 RNs on the shift.[94]

In this case, the Facility's report failed to display the information by category (it combined RN and LPN information into the single category of "licensed" staff), and it failed to break down the actual hours scheduled for each staff member within that category. The deficiency was properly cited and should be affirmed.

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[93] 42 C.F.R. § 483.30(e).
[94] 70 Fed. Register 62065, 62069 (Oct. 28, 2005).

Tag F373

The use of personal feeding assistants is governed by 42 C.F.R. § 483.35(h)(3). The regulation provides, in relevant part:

> Resident selection criteria. (i) A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. (ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. (iii) The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care.[95]

The Division maintains that the Facility failed to ensure that residents with complicated feeding problems were fed by licensed staff or nursing assistants instead of PFAs, creating an immediate jeopardy situation. The Facility maintains that it assessed these residents carefully and that nurses selected residents for PFAs based on the most recent assessment and plan of care, in compliance with the regulation; that it did not affirmatively document "eligibility" for a personal feeding assistant on care plans, and was not required to do so, but did document if a resident was not eligible; and that these residents did not have complicated feeding problems that made them ineligible for a PFA.

As an initial matter, the ALJ agrees with the Division that eligibility for use of PFAs should appear affirmatively in the care plan. A care plan must describe all services that are to be furnished a resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and services provided by the facility must be provided by qualified persons in accordance with the written plan of care.[96] If PFAs are permitted to feed a resident, in lieu of licensed staff or nursing assistants, the resident's eligibility for this service should appear on the care plan. The Facility's practice of documenting exceptions only did not comply with the regulations governing the development and revision of care plans.

When the rule authorizing the use of PFAs was adopted, CMS again provided a useful discussion of its rule as originally proposed and as modified. The purpose of the rule is to provide more residents with help in eating and drinking and reduce the incidence of unplanned weight loss and dehydration.[97]

As originally proposed, the regulation would have permitted the use of a paid feeding assistant for residents who do not have a clinical condition that would require the training of a nurse or nurse aide. Selection of residents to be fed was to be made by the professional nursing staff, using the comprehensive assessment. Commenters pointed out that the comprehensive assessment/annual evaluation is not an effective tool for the assessment of

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[95] 42 C.F.R. § 483.35(h)(3). State law permits the use of "resident attendants" to provide assistance with eating and drinking, except for residents who are at risk of choking while eating or drinking, present behavior management challenges while eating or drinking, or who present other risk factors that may require emergency intervention. *See* Minn. Stat. § 144A.62.

[96] 42 C.F.R. § 483.25(k)(1), (3).

[97] 68 Fed. Register 55528 (Sep. 26, 2003).

residents to be fed, because the information may not be current. Other commenters advocated the importance of the RN or LPN's professional judgment, along with input from the interdisciplinary team, as reflected in the comprehensive assessment, when selecting residents for feeding assistance. CMS agreed with both comments and revised the regulation to provide that the decision about whether a resident is to be fed by a feeding assistant is based on the charge nurse's assessment and the resident's latest assessment (not the comprehensive, annual assessment) and plan of care.[98]

In response to criticisms that the rule should define the clinical conditions that would require feeding by an RN, LPN, or nurse aide, CMS responded as follows:

> *We believe that the clinical decisions as to which residents may be fed by feeding assistants are best left to the professional judgment and experience of RNs and LPNs who work in the facility and have personal knowledge of a resident's day-to-day condition.* If we were to define clinical conditions, we would only be substituting the judgment of professional nurses employed by the Federal government for the judgment of nurses working in facilities. We believe that professional nurses conclude that certain clinical conditions relating to eating and drinking would require the skills and knowledge of an RN or LPN. These conditions include, but are not limited to, recurrent lung aspirations, difficulty swallowing, and tube or parenteral/IV feedings.[99]

Moreover, CMS declined to require that all persons who are fed by feeding assistants be fed together in a congregate area to ensure that a licensed nurse was physically present, reasoning that "the nurse in charge, using his or her professional judgment in assessing residents who are appropriate for feeding assistance, will be able to select residents who can safely be fed in their own rooms."[100]

This discussion suggests that a resident's eligibility to be fed by a personal feeding assistant is to be decided on a meal-by-meal basis by the charge nurse for that shift, based on the resident's day-to-day condition and on the latest assessment and plan of care. In determining the adequacy of a charge nurse's assessment of eligibility, the State Operations Manual provides as follows:

> Determine whether the charge nurse based her/his assessment of the resident's ongoing eligibility to be assisted by a paid feeding assistant on identification of the current condition of the resident and any additional or new risk factors or condition changes that may impact on the resident's ability to eat or drink. This information may be contained in the RAI [resident assessment instrument] or in other supporting documents such as progress notes, etc. The assessment of

[98] A facility is required to perform a comprehensive assessment at least annually and quarterly assessments every three months. *See* 42 C.F.R. § 483.20(b), (c).
[99] *Id.* at 55533 (emphasis added).
[100] Id. at 55534

eligibility to receive assistance from a paid feeding assistant is ongoing and should be in place from the day of admission.[101]

According to the State Operations Manual, noncompliance for F 373 may include the situation in which a resident who was assessed as being ineligible for services, or a resident who has not been assessed for eligibility, is being assisted by a PFA. The 2567 alleges that these residents were not eligible for assistance by PFAs, but the Division's arguments in the IIDR focus on something different--the alleged lack of assessment as to eligibility. In the Division's view, if eligibility for a PFA is not written explicitly in some document *specific to the use of PFAs*, the Facility cannot show that the residents were properly assessed as being eligible for use of a PFA. The Administrative Law Judge does not agree, given the language of the regulation and the ongoing nature of the assessments that are required for use of a PFA. What is written in the care plan itself is not determinative of a resident's eligibility for a PFA on any given day (unless the care plan provides the resident is ineligible). As the text of the regulation and its history make clear, eligibility is an ongoing process that is to be made on a day-to-day basis, by a charge nurse who is familiar with the resident's condition, and based on the resident's most recent assessment and plan of care.

In this case, the record reflects that the Facility selected residents for eligibility to be fed by PFAs based on nursing judgment as to the residents' condition each day; the most recent assessments of the residents; and the residents' plans of care. There was a specific policy that directed the documentation of eligibility by exception, and nurses were aware of the policy. There was also a specific policy with regard to residents using safe swallowing strategies, and nurses understood this was a safety issue to be decided by nurses in accordance with the regulation. The required comprehensive and quarterly assessments were made in a timely fashion.

The State Operations Manual also provides that noncompliance may include the situation in which a resident's clinical record does not show evidence of eligibility to receive assistance from a PFA. The clinical records of these residents support the nursing judgments made at the time of the survey that these residents did not *at that time* have complicated feeding problems. The error here was in failing to make the initial determination as to eligibility a part of the care plan, not in failing to accurately identify a complicated feeding problem. For these reasons, the ALJ concludes the facility should have been cited for deficient care plans (F 280), not for the deficient selection of residents for use of PFAs (F 373).

The facility also argues that the Division improperly found immediate jeopardy with regard to all of the above residents except for # 135. Immediate jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation has allowed, caused, or resulted in (or is likely to allow, cause or result in) serious injury, harm, impairment, or death to a resident; and this noncompliance requires immediate correction, as the facility either created the situation or allowed the situation to continue by failing to implement preventive or corrective measures.[102] Only one individual needs to be at risk, and serious harm, injury, impairment, or death does not have to occur before a determination of

[101] Ex. K-7.
[102] 42 C.F.R. § 489.3; Ex. G-28 (CMS Interpretive Guidelines for Surveyors).

immediate jeopardy is appropriate; the high potential for these outcomes to occur in the very near future also constitutes immediate jeopardy.[103]

In this case, there is insufficient evidence that immediate correction of the care plan deficiency was required to prevent a high potential for serious injury, harm, impairment, or death of a resident. The care plan deficiency should have been determined as severity level 2, no actual harm but with the potential for more than minimal harm that is not immediate jeopardy; and with a scope of 3 (a systemic failure).

K.D.S.

[103] Ex. D-1 to D-3 (SOM Appendix Q).